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ill-conceived and self-defeating. Medical aid of any nature, short of the emergency services as provided under the Canadian Red Cross, will be viable only in so far as it is integrated into the existing medical framework of the country or community receiving it. This is particularly true for Latin America which, Russian, American, or other influences notwithstanding, seeks and will find its own destiny under its own label.

Aid of any kind which runs counter to this trend stands a good chance of becoming sterile. But what this means in effect is that the type of medical aid necessary for Nigeria, or Korea, or Pakistan is not necessarily the type of aid suitable for Latin American countries. I feel that this point should be stressed because of the tendency of Canadians to continue thinking in an east-west rather than a north-south direction. To Dr. Murray's plea for balanced idealism I would therefore merely add the plea for increased attention on the part of Canadian doctors to the needs and requirements in the countries of South and Central America. We have ignored them long enough.

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EXTERNAL MARKERS FOR THALAMOTOMY

To the Editor:

In his article "Results of Thalamotomy for Parkinson's Disease" (*Canad. Med. Ass. J.*, 89: 652, 1963), Dr. T. J. Speakman refers to my article advocating the use of external markers so as to avoid the unpleasant effects of air studies in carrying out this operation (*Ibid.*, 87: 871, 1962).

The latter article referred to statistical studies which were carried out and showed that the localization of the target was as accurate with external markers alone as with air studies outlining the ventricular system. With either method, however, the safeguard of observing the effect of a temporary lesion in the conscious patient is always available, and one will modify the position of the target centre in relation to this effect rather than adhere rigidly to any co-ordinates, whether they be based on external markers or on portions of the ventricular system. Dr. Speakman's condemnation of my method of carrying out this procedure I cannot allow to pass unchallenged.

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To the Editor:

Dr. Paine's experience with external markers is quite different from that of anyone who has tried to design his own stereotaxic apparatus, or to prepare a stereotaxic atlas of brain sections using external cranial correlates. Reference to this experience will be found in most stereotaxic atlases.

Our experience in Edmonton indicates that the grossest errors will occur with the external marker technique in trying to determine the distance of the target area lateral to the midline in the AP projection. As indicated in my previously published article (*Canad. Med. Ass. J.*, 89: 652, 1963), this varied from 12 to 22 mm. and is the result of a phenomenon with which everyone is familiar, namely the variable dilatation of the ventricular system in older age and disease. Dr. Paine's technique ignores this problem entirely, as do the stereotaxic atlas makers.

In the growing field of human cerebral stereotaxic surgery it is important that we should all be seeking more accurate techniques for locating the targets. While the physiological result may be the most reliable, no one can afford to ignore the essential aid and greater safety provided by adequate radiographic visualization of the internal cerebral landmarks.

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TATTOOS AND IDENTITY

To the Editor:

Further to the highly elaborate tattoo mentioned at the beginning of the editorial entitled "Tattoos and Identity" (*Canad. Med. Ass. J.*, 89: 904, 1963), I saw this tattoo on at least four different individuals during the time that I was employed as a medical examining officer in induction stations during World War II. There have been other peculiar and striking pictorial representations including a coiled serpent tattooed on the lower abdomen with the picture extended distally so that the snake's head was tattooed on the glans penis. I have only seen one example of this latter tattoo but at least 10 examples of pictorial representation of houseflies or bees tattooed on a glans penis. One jovial "career soldier" had submitted to so many venereal "short-arm" inspections that he had the words "Hi, Doc" tattooed on the glans penis in such a way that it was exposed only when the prepuce was retracted. The induction examining team at the station in Springfield, Massachusetts, before my arrival there had observed a young lady applying for induction into the WAAC who had two cats' heads tattooed on the upper thighs in a direct line with her pudendum. This visual pun had earned her a living at stag shows and smokers.

All of the above tattoos were obviously executed by professionals. The subject content of the numerous amateur jobs was less elaborate but often more crude. It has been my practice for many years now to ask any person displaying a tattoo to tell me of the circumstances in which the tattoo was acquired. The commonest and almost universal experience is that professional tattoos were acquired when the one to be tattooed was in the company of several others and was drunk. Under these circumstances, the group had decided to be tattooed and then the individuals were too ashamed or embarrassed to back out. This was most common among servicemen, particularly in the Navy and the Marine Corps, who were stationed near some large seaport metropolitan area. Interestingly enough, subjects with multiple tattoos had the same experience on each occasion of acquiring a new picture or slogan. I am sorry now that I did not have these individuals photographed, as the pictorial representation plus case histories would make an interesting study of a psychosexual-social folkway.

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